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ABSTRACT

Many women seek treatment for substance abuse problems during their child-bearing years. Evaluations of interventions for these women need to take into account other problems that women may have when they enter treatment. The effectiveness of residential treatment for women, some of whom reported a history of abuse and psychological problems, is reported here. Data were collected on 101 women in two residential treatment programs. Both programs were federally funded, model demonstration programs designed to serve perinatal women and children under the age of three. Both facilities provided short-term residential treatment and their primary goals included reducing substance abuse and developing parenting skills. Parenting skills were addressed through the modeling of appropriate practices and through parenting classes in which the women and children were joint participants. As predicted, many women reported early abuse and symptoms of psychological distress. Women who reported severe psychological problems were less likely to graduate from the programs. Those who did graduate showed a reduction in the severity of their alcohol, drug, legal, family, and psychological problems. It is argued that interventions need to be developed and tested to meet the needs of women with both psychological and substance abuse disorders. Nine tables provide statistical data. (RJM)

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Substance Abuse, Clinical Needs, and Treatment Outcomes for Women

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Abstract

Programs which allow women to bring their children with them hold great promise for attracting those who would not otherwise seek help. Evaluations of these interventions need to take into account other problems that women may have when they enter treatment. In many instance, women with substance abuse problems have experienced early trauma and have concomitant psychological problems. The purpose of this study was to evaluate the effectiveness of residential treatment for women, some of whom reported a history of abuse and psychological problems. Data were collected on 101 women in two residential treatment programs in Southern California. As predicted, many women reported early abuse and symptoms of psychological distress. Women who reported more severe psychological problems were less likely to graduate. Clients who graduated from the six month programs showed a reduction in the severity of their alcohol, drug, legal, family and psychological problems. The importance of addressing the psychological needs of women with substance abuse problems is discussed.

Substance Abuse, Clinical Needs, and Treatment Outcomes for Women

Many women seek treatment for substance abuse problems during their child-bearing years. They may be motivated by their children to try to become sober (Deren, 1986; Vandor, Juliana, & Leone, 1991) yet fear leaving their children while they receive treatment (Dail, 1990; Institute of Medicine, 1990; Weitzman, 1989). Studies indicate that women are more likely to select less intensive, outpatient treatment, regardless of their needs, or to leave treatment prematurely, because of problems obtaining childcare (Duckert, 1987; Marsh & Miller, 1985).

Programs which allow women to bring their children with them, and which address parenting as well as substance abuse problems, have recently been implemented. Few evaluations of those efforts are currently available. One such program, MABON (Mothers and Babies Off Narcotics) was reviewed by Nunes-Dinis (1993). This program was reported to have a higher proportion of graduates (48%) than other residential programs serving a similar adult population without their infants.

Evaluation of substance abuse interventions for women, however, needs to take into account the other problems that women bring with them into treatment. In many instance, women with substance abuse problems have also experienced early trauma, including physical and sexual abuse (Institute of Medicine, 1990; Regan, Ehrlich, & Finnegan, 1987; Rohsenow, Corbett & Devine, 1988; Zweben, Clark & Smith, 1994). Studies also find that a high proportion of women seeking substance abuse treatment have psychological problems -- either as a primary diagnosis, secondary diagnosis, or as a co-existing illness along with their addiction (Anthenelli & Schuckit, 1993; Attia, 1989; Helzer & Pryzbeck, 1988; Lehman, Myers & Corty, 1989; Struening, Padgett, Pittman, Cordova & Jones, 1991). While some women seeking substance abuse treatment have more severe pathology (e.g., psychosis, schizophrenia) many women have disorders which do not require psychiatric hospitalization, such as long standing depression and

anxiety, which may, nevertheless, seriously impact their capacity to function with or without substances. Finally, chronic medical problems also are higher in clients with substance abuse and psychiatric problems (Wells, Golding & Burnam, 1989).

Studies on men with co-morbid psychiatric and substance abuse disorders find that those with the most severe psychiatric problems are less responsive to many types of substance abuse treatment (McLellan, Woody, Luborsky, O'Brien, & Druley, 1983a; 1983b). Similarly, Lyons and McGovern (1989) found that psychiatric patients with a history of substance abuse were more likely to leave treatment prematurely than other clients. On the other hand, McLellan and associates (McLellan, Luborsky, Woody, O'Brien, & Kron, 1981) also found that improvement in psychiatric functioning was associated with improvement in substance abuse and family problems. While there were few women in any of these studies, it is likely that similar problems will arise when treating this population.

Purpose

The purpose of this study was to determine the extent to which women entering residential substance abuse treatment programs also had a history of abuse and current psychological problems, and to evaluate the effectiveness of treatment, and the relationship of psychological functioning to treatment outcomes. The following hypotheses were tested:

1) Approximately 25% of women entering substance abuse treatment facilities were expected to have a prior history of abuse and/or psychological problems. It was hypothesized that clients with more serious current psychological problems would also have more serious medical, drug, alcohol and family problems.

2) It was expected that program retention would be related to initial psychological functioning; that is, it was anticipated that clients with more serious psychological problems would be less likely to graduate from a program.

3) Clients who graduated from a program were expected to show improvements across a number of areas, including medical, psychological and family functioning, as well as in their drug and alcohol use. Positive correlations were expected between psychological change scores and change scores in other domains.

4) Clients who graduated from the program were expected to maintain gains at last one month after leaving the program. Changes in psychological functioning were expected to correlate with maintenance of gains, particularly in the areas of substance abuse and family functioning.

Methods

Setting

Data were collected on women in two residential, substance-abuse treatment facilities, located within different cities, but the same county, in Southern California. Both were federally funded, model demonstration programs designed to serve perinatal women and children under the age of three. These programs were developed independently, but followed a common design. Each program provided short-term (six month) residential treatment to pregnant or parenting women with young children. The primary goals were reducing substance abuse and developing parenting skills. Substance abuse treatment was based on the 12 step model of recovery. Clients attended in-house and community based AA and NA meetings, relapse prevention, and 12-step study groups. Acupuncture, for detoxification, was also available. Parenting skills were addressed through modeling of appropriate practices and parenting classes in which the women and their children were joint participants (see Cosden 1995; 1996 for further details on these programs).

Clients

The programs served 101 women and their children over a five year period. Casa Rosa served 71 clients and Holly House 30; analysis of clients from both programs are combined in this paper. Client referrals came substance abuse treatment agencies, child

protective services, the courts, and former clients. Participation in either program was voluntary. Eligibility for the program, included : 1) having a low income; 2) being pregnant or parenting a child under the age of three; and 3) having a substance abuse problem and a stated desire for treatment.

The mean age of the women was 27.22 years, with a range between 18 and 39 years. Fifty-two percent of the women were European American, 25% Latina, 19% African-American, 3% Native American and 1% Asian-American. Twenty-seven percent of the women entered pregnant, and 73% entered postpartum.

The education and employment histories of the women were also obtained. The women's highest level of education ranged from 7th grade to college. Over half of the women (n=51) had not graduated from high school not did they have a GED. Thirty-nine women had a high school diploma or GED, and an additional 11 women had some college education. With regard to employment, clients ranged from 0-10 years of prior job experience. Clients averaged 2.3 years of prior job experience, although 33% reported no prior experience or less than a year of experience.

The clients' substance abuse histories are described in Tables 1 and 2. As noted, most of the women started drinking and using drugs as young adolescents. Length of sobriety on entry varied; longer periods of sobriety were evident for those coming from controlled environments (jail or other drug and alcohol treatment programs) and shorter periods for those coming directly from the community. By self-report, the women indicated alcohol and drugs, cocaine, and polydrug, as the most common patterns of substance abuse.

Insert Tables 1 & 2 about here

Instruments & Procedures

The Addiction Severity Index (ASI; McLellan, Kushner, Metzger, Peters, Smith, Grissom, Pettinati, & Argeriou, 1992) was administered to all clients. The ASI is a

structured interview for clients entering drug and alcohol treatment programs. Questions cover seven areas of personal functioning which may be directly, or indirectly, affected by substance abuse: medical health, employment history, alcohol use, drug use, legal concerns, family and social relationships, and psychological functioning. Within each area, the client's lifetime history, as well as their functioning over the past 30 days, are assessed.

Two types of subscale scores are obtained. Composite Scores are based on weighted client responses to objective questions in each domain; scores range from 0-1, with 0 reflecting no problems and 1 very serious problems. Severity Ratings reflect the interviewer's perceptions of the client's need for additional treatment and range from 0-8, with 0 representing no problems, and 8 reflecting very serious problems.

Adequate reliability of the ASI has been reported in several studies (Kosten, Rounsaville & Kleber, 1983; McLellan et al., 1992). The validity of the ASI has been determined through its association with other measures of substance abuse severity, and its utility in assessing subtypes of clients responsive to different types of treatment (McLellan et al., 1983). Composite scores are more reliable and useful for research purposes while severity ratings are more appropriate for clinical planning and appraisal of client performance. Nevertheless, both measures are often presented, and are analyzed in this study. While initial studies using the ASI were on male populations, the scale has been used effectively with a number of women's programs (Cosden, 1994; McLellan et al, 1992).

The ASI was administered by trained case managers at intake, at the end of the six month programs, and one month after returning to the community. In order to increase the likelihood of obtaining follow-up data in the community, clients were interviewed by familiar staff members and offered $10.00 grocery certificates for completing the assessments (Desmond, Maddux, Johnson & Confer, 1995).

Results

Psychological Characteristics of Clients

History of abuse and psychological symptoms described by clients are reported in Tables 3 and 4. As noted in Table 3, a majority of women reported a history of emotional abuse from someone close to them, over half noted physical abuse, and almost half reported prior sexual abuse. These data were obtained through self-report by clients at their intake to the programs.

Insert Tables 3 & 4 about here

A majority of women reported experiencing serious anxiety and depression at some time in their lives. Almost half reported prior thoughts of suicide, and over 40% had prior suicide attempts. The women were also asked about their history of treatment for these psychological problems; forty--two percent stated that they had received outpatient treatment for psychological problems, while 22% indicated that they had been hospitalized for psychological problems in the past.

Correlations between psychological composite scores, psychological severity ratings and other intake scores were calculated. As indicated in Table 5, clients with higher psychological composite and severity scores were also more likely to have higher medical, drug, alcohol and family scores. Thus, there was a moderate, positive relationship between psychological problems and medical, substance abuse, and family problems on entry to the programs. Legal and employment problems were not related to initial psychological functioning.

Insert Table 5 about here

Program Retention

Clients remained in the program an average of 132.44 days, SD= 80.24, range 1-365 days. Reasons for leaving the program are noted in Table 6. As indicated, approximately 44% of clients were program graduates. The others either left voluntarily, because they did not feel ready for the program or wanted to join other family members; or they were asked to leave, as a result of continued drug use or violence toward others in the program. Only one client left to receive more intensive psychological services.

Insert Table 6 about here

Factors related to program retention were assessed by correlating initial ASI scores with time in the program. The only significant correlation found was between psychological composite scores and time, $r(96) = -.24$, $p<.05$. Thus, clients with more serious psychological problems were less likely to remain in the program. Other factors, including the legal status of the clients, as assessed by composite scores and whether or not treatment was prompted by the justice system, were not associated with program retention.

Progress in the Program

Client progress was assessed at the end of the six month programs by comparing intake and six month ASI scores using a series of paired t-tests. For clients who remained at least six months in a program (i.e., program graduates) significant changes in composite scores were noted for alcohol, drug, legal, family and psychological problems (see Table 7).

Insert Tables 7 about here

Difference scores were calculated for each domain reflecting the level of change clients experienced over the six months in treatment. As noted in Table 8, change in psychiatric composite scores was highly correlated with changes in medical, alcohol and drug composite scores, while change in psychiatric severity ratings was correlated with change in family, legal, alcohol and medical ratings. Few other change scores were correlated with each other.

Insert Table 8 about here

Maintenance of Outcomes in the Community

Maintenance of client progress was assessed by comparing their intake scores with those obtained after clients had been out of a program for one month. A series of paired t-tests was used to assess outcomes for clients who had graduated from the programs. Twenty-two of the 44 clients who had graduated from the programs, and 34 of the 57 non-graduates were interviewed in the community; others had either moved out of the area or were not willing to participate further in the study. As indicated in Table 9, those graduates interviewed had improved drug and legal scores relative to their scores at intake.

Insert Table 9 about here

Difference scores were calculated between intake and one month out ASI scores for all clients (N=56) interviewed in the community. Change in psychiatric composite scores was correlated with change in drug composite scores, $r(56) = .26$, $p<.05$, while change in psychiatric severity ratings was correlated with change in family functioning, $r(55) = .50$, $p<.01$, and drug use, $r(56) = .33$, $p<.05$.

Table 7

Changes in ASI Scores For Clients Graduating from Treatment (N=42)

	Intake		Six months		
ASI Domain	M	SD	M	SD	t
Medical Composite	.29	.34	.26	.33	.49
Medical Severity	2.45	2.58	2.24	2.35	.47
Employment Composite	.83	.20	.78	.21	1.44
Employment Severity	4.40	2.08	4.14	2.03	.64
Alcohol Composite	.20	.23	.16	.11	1.12
Alcohol Severity	5.17	2.29	4.33	2.04	2.04*
Drug Composite	.16	.10	.09	.04	4.30**
Drug Severity	6.81	1.35	5.43	1.53	5.73**
Legal Composite	.23	.19	.11	.16	3.79**
Legal Severity	4.12	2.31	2.43	2.13	4.17**
Family Composite	.39	.19	.26	.19	3.60*
Family Severity	6.07	1.42	4.21	1.62	6.27**
Psychological Composite	.27	.21	.19	.20	1.98*
Psychological Severity	4.39	2.09	2.62	2.56	4.20**

* $p < .05$

** $p < .001$

Table 6

Reasons for Leaving Programs

Reasons	N	%
Graduated	44	43.56
Felt unready for program	23	22.77
Continued drug use[a]	13	12.87
Engaged in violence	6	5.94
Wanted to join partner	5	4.95
Program ended	4	3.96
Wanted to join other children	2	1.98
Probation period over	2	1.98
Concerned about law	1	.09
Needed psychological services	1	.09

Table 5

Correlations Between Psychological Functioning and Other Problems at Intake

ASI Domain	Psychological Composite Score	Psychological Severity Score
Medical Composite	.283**	.163
Medical Severity	.223*	.338**
Employment Composite	-.012	.062
Employment Severity	-.009	.114
Legal Composite	-.098	.141
Legal Severity	-.145	.047
Alcohol Composite	.305**	.270**
Alcohol Severity	.188	.353**
Drug Composite	.421**	.352**
Drug Severity	.122	.305**
Family Composite	.319**	.376**
Family Severity	.193	.592**

* $p<.05$

** $p<.01$

Discussion

This study supports other investigations (e.g., Regan et al., 1987; Rohsenow et al., 1988; Zweben et al.., 1994) in finding a high likelihood of early physical and sexual abuse among women seeking substance abuse treatment. A majority of women had also experienced serious depression and/or anxiety, and many had attempted suicide. The clients in this study were not overtly psychotic; however, they suffered a variety of psychiatric symptoms, as well as substance abuse problems, over long periods of time. Thus, they appeared similar to subgroups of clients described by Struening et al. (1991) and others. Given the early abuse experienced by many, it is possible that the affective disorder was primary, and the substance abuse secondary, at least for some of the women (Attia, 1989; Zweben et al., 1994). However, other aspects of their lives (e.g., family histories of alcohol and drug abuse) suggest that the substance abuse and psychiatric symptomotology may have developed independent of one another. Clients who reported more psychological problems also indicated that they had greater substance abuse, family and medical problems.

Little is known about typical program retention and progress in treatment for the types of clients served in this program. Thus, it is hard to evaluate whether the 44% graduation rate reflects a higher or lower standard than should be expected of similar clients. This rate is comparable to that reported by Nunes-Dines (1993) for MABON in New York, and higher than the rates cited by her for treatment programs which do not allow women to bring children with them. Further comparison and evaluation of retention rates across programs depends on the availability of studies in which clients, programs, and graduation criteria are clearly described.

Both programs were designed to meet the needs of women who were either pregnant or had young children (Finkelstein, 1993). In one program (Casa Rosa) women were allowed to bring one child with them, while in the other (Holly House) they were able to bring more than one child as long as the children were no older than three years of age.

Both programs allowed weekend visitation with older children. As a result of this family structure, only two women left either program because they wanted to be with their other child(ren). Further accommodation to family needs (i.e., allowing women to bring all of their children with them into treatment) needs to be weighed against the ability of the women to care for multiple children while they are going through the early stages of recovery. While many of the women had to make accommodations for older children, or delay reuniting with them until after treatment, this allowed the women time to focus on their own needs for treatment as well as on their child(ren)'s needs.

As was predicted, clients with higher levels of psychological problems were less likely than other clients to graduate from a program. This supports other studies which find that clients with both substance abuse and psychiatric problems are more difficult to treat, and do less well after treatment (McLellan et al., 1983a; 1983b; Lyons & McGovern, 1989). While both programs did offer counseling to their clients, the effectiveness of that counseling, and its integration with the substance abuse interventions, are unclear. Models for integrating psychological and substance abuse treatment, particularly for women who have histories of abuse, are in their early developmental stages (Brower, Blow & Beresford, 1989; Zweben et al., 1994). The timing of clinical interventions which would address early abuse and psychological dysfunction in relation to the stability of the client's sobriety is of particular concern. If clients discuss stressful events too early in their sobriety, they may relapse as a form of self-medication; if, on the other hand, discussion is delayed, clients may feel the psychological impact of the early trauma as they become sober and relapse, or leave treatment, if they feel their needs are not being met. It is recommended to balance the client's need to address her emotional discomfort with her need to feel safe in her sobriety. Given the large proportion of women in substance abuse treatment indicating histories of abuse, depression, and anxiety, both in this and in other studies (e.g., Institute

of Medicine, 1990; Regan, et al., 1987 Rohsenow, et al., 1988), methods for addressing the psychological needs of these women require further study.

While not the primary focus of this study, it was noted that women who entered the program through the justice system were as likely to graduate as were clients who entered without legal involvement. This joins a growing body of literature questioning the popular myth that clients mandated into treatment through the justice system will be less motivated and less successful in treatment.

Clients who stayed in the program for six months indicated a reduction in the severity of their substance abuse, legal, family and psychological problems relative to the severity of these problems at intake. These changes reflect the primary goals of the program, which included dealing with old warrants, improving parenting skills, and reducing substance abuse. These findings are similar to those of Hubbard, Marsden, Rachel, Harwood, Cavanaugh, and Ginzburg (1989) who noted a simultaneous reduction of drug abuse and illegal activities among their clients. McLellan, et al. (1983a, 1983b) also found that clients who reduced their drug use showed a concomitant improvement in other areas of their lives. Further, as noted in this study, change in psychological functioning was related to positive changes in other areas. Thus, for clients who remained in treatment, progress was seen on a number of dimensions.

Graduates who were interviewed in the community indicated that, overall, they had maintained their progress. However, a major limitation of this study is the lack of follow-up data on clients. The low response rate was a function of client availability; this could be interpreted as a failure of other clients to maintain their sobriety and their interest in the program. Other data are available on clients after leaving these programs and will be analyzed in future papers.

In addition to the problems obtaining follow-up data, there are other limitations to this study. The data presented in this paper were based on self-report by clients in a treatment program and in the community. While efforts were made to elicit honesty (e.g., clients

were assured of their confidentiality and were not threatened with legal sanctions as a function of their responses) they may still under or over-identify problems. Further, this study did not utilize a control or contrast group, nor are there many studies available which provide data for comparison. Thus, we can not determine whether other types of treatment would have resulted in similar, or better, results. As more programs for women are evaluated, knowledge regarding client-treatment matching for women will be enhanced.

Conclusion

In sum, this study demonstrated that many women entering substance abuse treatment have a concomitant need to deal with early abuse, depression and anxiety. If untreated, these clients are more likely to drop out of treatment. Clients who remained in residential treatment demonstrated gains in several areas; gains in psychological functioning were associated with reductions in drug use and improvements in medical and family functioning. Interventions need to be developed, and tested, to meet the needs of women with both psychological and substance abuse disorders.

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Table 1

Substance Abuse Histories of Women Entering Treatment

History	N	M	SD	Range
Years of substance abuse	101	11.61	5.24	1-24
Age of first drink	101	13.88	3.72	5-26
Age of first drugs	101	15.62	4.15	5-28
Length of sobriety on entry to program (months)				
From the community	63	1.05	1.97	0-8
From jail	29	3.01	2.29	0-9
From another program	9	2.03	2.61	0-6
From any setting	101	1.68	2.24	0-9

Table 2

Primary Substance of Women Entering Treatment

Substance	N	%
Alcohol & Drugs	33	32.67
Cocaine	25	24.75
Polydrug	20	19.80
Heroin/Opiates	9	8.91
Alcohol	6	5.94
Amphetamines	6	5.94
Cannabis	2	1.98

Table 3

History of Abuse

Type of Abuse	N	%
Emotional Abuse	89	88.12
Physical Abuse	69	68.32
Sexual Abuse	46	45.54

Table 4

History of Psychological Problems

Symptom	N	%
Serious anxiety	75	74.26
Serious depression	70	69.31
Trouble concentrating/understanding	47	46.53
Thoughts of suicide	49	48.51
Attempted suicide	41	40.59
Trouble controlling violent behavior	44	43.56
Hallucinations	13	12.87

Table 5

Correlations Between Psychological Functioning and Other Problems at Intake

ASI Domain	Psychological Composite Score	Psychological Severity Score
Medical Composite	.283**	.163
Medical Severity	.223*	.338**
Employment Composite	-.012	.062
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Legal Severity	-.145	.047
Alcohol Composite	.305**	.270**
Alcohol Severity	.188	.353**
Drug Composite	.421**	.352**
Drug Severity	.122	.305**
Family Composite	.319**	.376**
Family Severity	.193	.592**

* $p<.05$

** $p<.01$

Table 6

Reasons for Leaving Programs

Reasons	N	%
Graduated	44	43.56
Felt unready for program	23	22.77
Continued drug use[a]	13	12.87
Engaged in violence	6	5.94
Wanted to join partner	5	4.95
Program ended	4	3.96
Wanted to join other children	2	1.98
Probation period over	2	1.98
Concerned about law	1	.09
Needed psychological services	1	.09

a Clients were allowed to stay in the programs after a relapse (determined through drug testing) if they were willing to admit to their problems.

Table 7

Changes in ASI Scores For Clients Graduating from Treatment (N=42)

	Intake		Six months		
ASI Domain	M	SD	M	SD	t
Medical Composite	.29	.34	.26	.33	.49
Medical Severity	2.45	2.58	2.24	2.35	.47
Employment Composite	.83	.20	.78	.21	1.44
Employment Severity	4.40	2.08	4.14	2.03	.64
Alcohol Composite	.20	.23	.16	.11	1.12
Alcohol Severity	5.17	2.29	4.33	2.04	2.04*
Drug Composite	.16	.10	.09	.04	4.30**
Drug Severity	6.81	1.35	5.43	1.53	5.73**
Legal Composite	.23	.19	.11	.16	3.79**
Legal Severity	4.12	2.31	2.43	2.13	4.17**
Family Composite	.39	.19	.26	.19	3.60*
Family Severity	6.07	1.42	4.21	1.62	6.27**
Psychological Composite	.27	.21	.19	.20	1.98*
Psychological Severity	4.39	2.09	2.62	2.56	4.20**

* $p < .05$

** $p < .001$

Table 8

Correlations Between Difference Scores: Changes from Intake to Program Graduation (Six Months of Treatment)

ASI Domain	Psych. Composite Difference Score	Psych. Severity Difference Score
Medical Composite Difference Score	.431**	.399**
Medical Severity Difference Score	.415**	.346*
Employment Composite Difference Score	.002	.100
Employment Severity Difference Score	-.020	.121
Legal Composite Difference Score	.295	.227
Legal Severity Difference Score	.235	.304*
Alcohol Composite Difference Score	.516**	.486**
Alcohol Severity Difference Score	.248	.366*
Drug Composite Difference Score	.346*	.307*
Drug Severity Difference Score	.231	.094
Family Composite Difference Score	.015	-.128
Family Severity Difference Score	.197	.441**

* $p<.05$

** $p<.01$

Table 9

Progress of Graduates One Month Out of the Program (N=22)

	Intake		One Month Out		
ASI Domain	M	SD	M	SD	t
Medical Composite	.14	.23	.15	.26	-.12
Medical Severity	1.59	2.15	1.57	2.29	.20
Employment Composite	.84	.21	.83	.22	.57
Employment Severity	5.05	1.46	4.48	1.54	1.98
Alcohol Composite	.23	.19	.21	.18	.30
Alcohol Severity	5.45	2.60	5.05	2.18	.92
Drug Composite	.13	.07	.08	.06	3.97**
Drug Severity	6.73	1.58	5.48	2.25	3.19*
Legal Composite	.25	.21	.09	.12	3.92**
Legal Severity	3.96	2.42	2.05	2.20	3.19*
Family Composite	.41	.17	.33	.20	1.59
Family Severity	6.14	1.61	5.24	1.81	1.75
Psychological Composite	.28	.23	.21	.20	1.50
Psychological Severity	4.59	1.92	3.52	2.62	1.85

* $p<.05$

** $p<.01$